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ORIGINAL LECTURES.

A CLINICAL LECTURE ON THE TREATMENT OF PRIMARY VENEREAL SORES IN PROFESSOR SIGMUND'S WARDS.

BY HEINRICH PASCHKIS, M.D.,

Allgemeines Krankenhaus, Vienna.

Reported by C. WINSLOW DULLES, M.D.

IN the treatment of primary venereal sores it does not make any practical difference whether the surgeon be a unicist or a dualist; for in many cases nothing less than an observation for a period varying from four to as many as seven or even eight weeks will suffice to determine absolutely whether he has to deal with a simple or soft chancre or a hard or Hunterian chancre. A suspicious sore upon the genitalia, appearing after an impure connection, should always be treated so as to give the patient the benefit of every possible doubt.

With this object most surgeons practise thorough cauterization; while there are not wanting a few who believe that a careful enucleation of the indurated chancre will protect the patient against subsequent syphilitic developments. The latter method is utterly rejected here, while the former is almost universal, and that which is taught and practised in these wards.

The desiderata in a cauterant are that it shall destroy all animal and vegetable organisms with which it comes in contact, that it shall make a good eschar, and that its action may be limited as desired.

These are not attained by the nitrate of silver, which is sometimes injudiciously used. Its action is by far too superficial, and it leaves such discoloration as renders it almost impossible afterwards to learn anything by inspection of the parts.

On the other hand, the best and simplest cauterant we have is the one least used. I mean the actual cautery, the hot iron. Its action is thorough, it can be limited with great ease, and it leaves the best eschar possible. Unfortunately, its use is objected to by patients, who dread the pain, although actually this is less than that caused by the chemical cauterants. The hot iron, when practicable, is a simple method, requiring no apparatus: one may employ a knitting-needle, heated in any flame, and it may prove of great service in cauterizing fistulous tracks and sinuses, such as so often are seen about suppurating buboes and the like.

Next in strength after this cauterant come the stronger mineral acids, nitric and sulphuric. Before their use the sore should be made as dry and clean as possible, and they should then be applied with a glass rod or a pointed piece of wood. Sulphuric acid is not infrequently made into a paste with charcoal, and thus applied.

These acids are excellent cauterants, but there is some difficulty in accurately limiting their action.

The styptic salts of iron, especially the perchloride, are sometimes used, particularly in cases where there is a strong tendency to hemorrhage.

The chloride of zinc is often used in the strength of one part to eight parts of water, being a thorough caustic, but a frightfully painful one.

In these wards the solution of the sulphate of copper is employed more than any other cauterant, as we think it the best for the majority of cases. Its merits are that it does not injure the surrounding healthy tissue, its action can be accurately limited, and it does not leave a dirty eschar, nor disguise what goes on after its application, nor stain the linen as some other caustics do. We use it in solution of one part sulphate of copper and three parts water. This is applied with a piece of cotton tied to a stick or a camel's-hair pencil, after thoroughly drying the part, and repeated from three to six times a day, until the sore is converted into a healthy granulating one. For the pain, which is often intense, we employ cold applications.

For walking patients I have had made gelatine plates impregnated with the latter two salts, from which pieces may be cut and applied with plaster. The gelatine dissolves, and the salts are brought into contact with the sore.

For sores that have assumed a gangrenous or unhealthy appearance, various preparations have been recommended as antiseptics, among which carbolic acid is the best. The sores should be cleansed

with a solution of one part in a hundred parts water, and as a cauterant it should be used in a strength of ten to one hundred of alcohol, or equal parts of carbolic acid and glycerin, or even pure carbolic acid. It should never be used suspended in oil, because this diminishes its action and makes a dirty application, and uncleanliness must always be avoided, for it is one of the most serious obstacles to correct diagnosis and successful treatment.

As an application after cauterization I can most highly recommend a mixture of one part tar with nine parts gypsum, rubbed together until a slightly cohesive powder is secured, conveying, when rubbed between the fingers, a feeling which simulates greasiness. For primary sores, as well as suppurating glands, it acts as an absorbent and deodorizer of the discharges.

Cauterants are only employed until the sores become clean and present a healthy granulating appearance. When this is attained we use applications of indifferent salts. The chlorate of potash, or any antiseptic in weak solution, say one per cent., will serve to keep the wounds clean, and does not irritate. In certain cases we deem it advisable to stimulate the granulations to quicker cicatrization by application of solution of corrosive sublimate one part in a hundred parts of alcohol; or one of iodide of potassium ten parts, iodine one part, and water a thousand parts. In most cases we do not find this necessary.

When the sores are clean and doing well, we cover them with plaster or cotton and plaster, after the method of Guérin, for twenty-four hours, with which occasional light cauterization of the margins with a crayon of nitrate of silver is often combined advantageously.

ORIGINAL COMMUNICATIONS.

BLEPHARITIS AND AMETROPIA.

BY P. D. KEYSER, M.D.,

Surgeon to the Wills Eye Hospital, Philadelphia.

IN the discussion at the International Ophthalmological Congress last September, on the paper of Dr. Roosa, entitled, "On the Relations of Blepharitis Ciliaris to Ametropia," I remarked that I had for more than two years noticed this connection, and have been in the habit of examining every case of blepharitis that comes to my office for errors of refraction, and have never failed to discover some one or the other, if not a combination of anomalies.

To substantiate the correctness of Dr. Roosa's remarks as well as my own, I present the following statistics of cases observed in my private practice the past year (1876).

February 7.—Mr. F., æt. 19. Has had blepharitis the past two years. Lids always worse on use of the eyes.

V = $\frac{20}{XX}$; after atropine, $\frac{20}{XXX}$; with +48 = $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{48}$.

February 25.—Mr. C., æt. 28, complains that for years he has had trouble with the edges of his lids.

L. E., convergent strabismus 1‴;

L. E., V = $\frac{2}{C}$;

R. E., V = $\frac{20}{XL}$; after atropine, $\frac{20}{LXX}$;

R. E., with +9, V = $\frac{20}{XX}$.

L. E., with +9, V = $\frac{10}{C}$.

Since use of glasses, no return of blepharitis.

February 27.—Miss H., æt. 15; blepharitis the past year.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +36, $\frac{20}{XX}$.

Hypermetropia = $\frac{1}{36}$.

February 29.—Mr. M., æt. 24; blepharitis for the past two or three years.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XL}$; with +36, $\frac{20}{XX}$.

Hypermetropia = $\frac{1}{36}$.

March 3.—Master J., æt. 16; the past year has been applying his eyes to close and fine work in a machine-shop, and has noticed an inflammation and eruption on the edges of the lids.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +36, $\frac{20}{XX}$.

Refraction, hypermetropia, $\frac{1}{36}$.

March 7.—Master McC., æt. 10; edges of the lids inflamed the past six months; always worse on attempting to study.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +42, $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{42}$.

March 17.—Miss G., æt. 20; edges of the lids inflamed for some time. Cannot read nor sew with comfort; pain in the eyes and over brow, and in the back of the head.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XL}$.

R. E., $+40 \supset +60^c$, 90°, V = $\frac{20}{XX}$.

L. E., $+48 \supset +60^c$, 90°, V = $\frac{20}{XX}$.

Refraction, compound hypermetropic astigmatism.

March 22.—Master G., æt. 14; blepharitis for three or four years; reads much; lids always worse.

V = $\frac{20}{XX}$; after atropine, $\frac{20}{XXX}$; with +48, $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{48}$.

March 29.—Mr. D., æt. 28. For the past five years edges of the lids have been inflamed; kept pulling the ciliæ out, but no relief.

V = $\frac{20}{XXX}$; after atropine, $\frac{20}{LXX}$; with +20, $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{20}$.

April 8.—Miss G., æt. 24; blepharitis.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +48, $\frac{20}{XX}$.

Insufficiency of L. rectus internus, 4°.

May 22.—Mr. C., æt. 23; blepharitis.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XL}$; with +30, $\frac{20}{XX}$.

Refraction, hypermetropia, $\frac{1}{30}$.

June 5.—Mr. McL., æt. 26; blepharitis R. E. the past two years; nothing would cure it.

R. E., V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +48, $\frac{20}{XX}$.

L. E., V = $\frac{20}{XX}$; after atropia, $\frac{20}{XX}$; emmetropic.

The R. E. recovered soon after the use of the glass, and has remained well ever since.

June 19.—Mrs. H., æt. 25; has had blepharitis since nine or ten years of age; has tried everything without a successful and permanent cure.

V = $\frac{20}{XXX}$; after atropia, $\frac{20}{LXX}$; with +30, $\frac{20}{XX}$.

In one week after wearing the glasses and treatment, the lids were almost well, since which time she has had no return of the old inflammation.

July 7.—Mr. B., æt. 26; lids have been inflamed for some time.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +42, $\frac{29}{XX}$.

Hypermetropia, $\frac{1}{42}$.

August 12.—Mr. W., æt. 28; for three or four years his eyes have troubled him; is a bank clerk, and every day about noon there comes a pain in the head, which remains until finished with his duties; edges of the lids are much inflamed.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{C}$; with +16, $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{16}$.

Since using the glasses, lids have recovered their natural look, and there is no return of the daily pain in the head.

October 17.—Master L., æt. 14; blepharitis the past six months.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +42, $\frac{20}{XX}$.

Refraction, hypermetropia, $\frac{1}{42}$.

October 19.—Mr. A., æt. 31; for several years eyelids have been red and scaly.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XX}$; dim, $+48^c$, 90°, $\frac{20}{XX}$ sharp.

Simple hypermetropic astigmatism, $+48^c$, axis 90°.

October 30.—Master A., æt. 15; blepharitis five years' duration.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +48, $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{48}$.

November 7.—Mr. S., æt. 30; blepharitis one and a half years.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XXX}$; with +48, $\frac{20}{XX}$.

November 10.—Miss P., æt. 20; for a year past, blepharitis.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XL}$; with +30, $\frac{20}{XX}$.

November 15.—Miss W., æt. 19; blepharitis for over two years.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XL}$; with +36, $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{36}$.

December 6.—Mr. J., æt. 27, has had inflammation of the edges of the eyelids for six years; has undergone much treatment without any benefit.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{LXX}$; with +24, $\frac{20}{XX}$.

Since the use of the glasses, eyes have improved steadily, and are now almost well.

December 8.—Mr. H., æt. 21; blepharitis the past year. The lids are better when not using his eyes.

V = $\frac{20}{XX}$; after atropia, $\frac{20}{XL}$; with +30, $\frac{20}{XX}$.

Hypermetropia, $\frac{1}{30}$.

The accommodation was paralyzed in all the cases before the examination was made, so that a complete result could be obtained.

It will be noticed that all the cases were hypermetropic, and in a very great majority of them of a low degree; only two being astigmatic.

I have never seen a case of marked blepharitis get entirely and permanently well under the ordinary treatment until the defect in refraction has been corrected, although the remedies used would improve and apparently cure the disease, but in a short time a relapse would occur, and the shorter would be the time for the relapse, if the eyes were used steadily and much at fine or close work.

Exact observation of such cases is what is needed now, and accumulations of experience may show the fact of ametropia being in many if not all cases the direct cause of blepharitis.

In the case of date June 5, above described, the hypermetropia was the cause of the blepharitis without doubt, as the lids of the one eye only were affected, and this was the hypermetropic one, while the other was normal and no defect of refraction could be found.

In my clinic during the same time there were twenty-four cases of blepharitis, all of which could not be examined under the action of atropia, but by the ophthalmoscope were determined, five hypermetropes of $\frac{1}{48}$, five of $\frac{1}{36}$, one of $\frac{1}{42}$, three of $\frac{1}{30}$, one of $\frac{1}{24}$, one of $\frac{1}{20}$, one of $\frac{1}{16}$, and one presbyope of $\frac{1}{36}$, four not determined, of which one was only two years old, two of three years, and one four years of age.

The question would naturally arise, "How can ametropia be a cause of blepharitis?"

That ametropia of any kind or form causes in all acts of vision a strain more or less upon the eye, which creates a fulness or hyperæmic condition of the neighboring parts, is a well-known fact, as is seen in many such cases by red and congested conjunctiva and edges of the lids. In cases where the strain is such as to create a continued hyperæmia of the edges of the lids, the extremely fine ducts and external openings of the small sebaceous glands (Zeiss's glands) that are to be found in the canals and follicles of the ciliæ become closed by pressure from the swelling of the tissue and vessels surrounding them, and having no outlet for the natural secretions, which are now increased by the hyperæmic condition, a choked status is formed, and inflammation and suppuration take place, as is noticed in the little pus bead that is found encircling the cilia and extending down the canal to the gland.

Rest of the eyes, with proper local treatment, removes in time this suppurative and inflammatory action and apparently the whole disease is cured; but on resuming active use of the eyes the same condition of hyperæmia returns, with eventually the whole former trouble.

But when the ametropia is corrected, and the strain on the eye removed, there will be no return of the condition of hyperæmia, and a perfect cure of the blepharitis can be made.

Since the meeting of the congress I have looked over the following recent works on ophthalmology: Stellwag, Wecker, Galezowski, Schweigger, Wells, Graefe und Saemisch, Tetzer-Gruenfeld, Von Graefe's Archiv, Zehender's Monatsblätter, Ophthalmic Hospital Reports, Annales d'Oculistique, Journal d'Ophthalmologie, Archives for Ophthalmology and Otology, Donders on Accommodation and Refraction, and Nagel's Jahresbericht, without finding any mention of this connection of ametropia and blepharitis. So that Dr. Roosa is the first to publish the fact and call attention thereto, although, without any communication with him, I have known and acted upon it in my practice for more than two years, and brought it to the notice of some of my colleagues.

1630 Arch Street, January 22, 1877.

THE CONDUCTING POWER AS DISTINCT FROM THE RECEIVING POWER OF THE NERVE.

BY B. F. LAUTENBACH, M.D.

ON reading the various works relating to the physiology of the nerves, we find, with one exception, that the authors always speak of the conduction of an irritation without alluding to the circumstance that *the nerve must receive before it can conduct an irritation*, and that this receiving of an irritation must of necessity occupy time, even though this be very short.

I say with one exception, as in the book of Schiff (Muskel- u. Nervenphysiologie, 1859)—a book which, as has been truly said by Professor Nothnagel, is an inexhaustible mine of facts relating to the physiology of the nervous system—this difference is spoken of. This author says (p. 140), "Die Erregbarkeit des Nervens, d. h., seine Fähigkeit eine äussere Einwirkung in Nerventhätigkeit zu übersetzen, und die Leitungsfähigkeit durch die er jene

Thätigkeit in der Richtung seiner Längsaxe überträgt und anderen Geweben mittheilt, sind zwei verschiedene Eigenschaften."

Later the same author (Zeitsch. f. ration. Med., 1868) found when he compressed a portion of the sciatic nerve of a frog, so as to destroy the medullary substance, and allowed the degeneration in the lower portion of the nerve to begin, that the nerve is still able to conduct impulses of the "will," and that the muscle contracted normally on irritating the nerve above the compressed portion, although irritation of the nerve below the compressed portion had little or no effect.

From these experiments Schiff again concluded that a difference existed between the receiving and the conducting power of the nerves. This conclusion has been called in question by Wundt (Lehrb. d. Physiologie, p. 495), who thinks that the results obtained by Schiff may be due to "a greater resistance offered to the conduction of the currents in the degenerating portion of the nerve."* But this is simply absurd, as the higher irritation has to encounter the same resistance in passing through the degenerating portion of a nerve as the conduction of an irritation directly applied to this degenerated portion encounters.

This experiment the author has repeated a number of times, and always found a confirmation of the results obtained by Schiff.

The following are a few of a number of experiments made by the author in another manner,—and before knowing of the previous experiments of Schiff,—which convinced him that the difference between the receiving and the conducting power of the nerve really exists.

Experiment 1. On a large female Rana esculentia.—After the left sciatic nerve at the lower portion of the thigh had reacted to comparatively weak irritation for fifteen minutes, the strongest induction currents (two large Bunsen cells) were no longer able to cause it to react. The muscle was now taken, and it was found to respond to slight irritations, as is usually the case under these circumstances. Being surprised that irritation of the nerve ceased to produce contraction of the muscle at so early a period of the experiment, I wished to see if reflex contractions were still present in the opposite limb; but, to my astonishment, irritation of the skin of the uninjured extremity *not only produced reflex contractions in the muscles of the same side, but also in the muscles of the opposite side; i.e.*, a nerve that was no longer able to respond to direct irritation was still able to conduct an irritation received through the medium of the spinal centres (the brain and upper portion of the spinal cord had been destroyed) from the opposite extremity. The sciatic nerve was now completely separated from the other tissues of the thigh, which were removed and the irritation of the nerve repeated without producing the slightest movement in the gastrocnemius; the irritation of the skin of the opposite extremity was now again made, and the left gastrocnemius contracted so as to draw the lever of the myographion to the height of 8 mm.

Experiment 2. Male R. esculentia.—The right sciatic nerve was irritated at a point just above the knee by means of a very strong induction current without causing the slightest contraction in the gastrocnemius, but irritation of the skin of the opposite extremity, as also of the skin of the same extremity, caused it to contract strongly. Thinking that this result might be due to an anomaly in the distribution of the nerves, I removed the whole right thigh, leaving the gastrocnemius connected with the rest of the muscle only by means of its nerve. The nerve was again irritated, with the previous effect, *i.e.*, with absolutely no effect; while irritation of the skin of the opposite extremity produced contractions of the gastrocnemius of the injured extremity.

Experiment 3. Large female R. temporani.—The right sciatic nerve never reacted. Irritation of the skin of either limb causes reflex contractions in the gastrocnemius of the injured limb.

These experiments show very plainly that the conducting power of a nerve may be present when the receiving power is absent, for otherwise it would be impossible to explain why a nerve can conduct an impression received from the centre and not a much stronger one applied to it near its periphery.

An interesting experiment, which shows that the same difference exists in the nerve in the muscle, is the following:

Experiment 4. Rana esculentia.—Two poles from an induction apparatus were brought into the muscle (one through the tendon of the gastrocnemius, and the other near its origin) and two poles were applied to the plexus on the same side. The irritation of either muscle or nerve could be made with the same current by means of a Pohl communicator. After the seventeenth irritation, the muscle ceased to respond to the strongest currents directly applied to it, but when a very weak current was applied to the plexus, the muscle contracted, drawing the lever of the myographion to the height of 5.9 mm.

* "Zunahme des galvanischen Leitungsfähigkeit in dem degenerirenden Nervenstück," says Wundt.

The fact that this difference between the receiving and the conducting power of the nerve really exists, will explain the anomalous cases of curare and conia poisoning, where voluntary and reflex movements continued though the direct irritation of the nerves caused no contraction of the muscles. Its great importance, however, will be seen when the author has presented his experiments on the "*velocity of conduction in the nerves*," which he will probably be able to do in a short time.

PHYSIOLOGICAL LABORATORY OF GENEVA,
January 24, 1877.

COMPOUND DISLOCATION OF THE KNEE, TREATED BY POWERFUL EXTENSION AND COUNTER-EXTENSION, RESULTING IN A PERFECT CURE.

BY J. D. DAVIS, M.D.

SAMUEL G., aged 19 years, robust, of very temperate habits, received on the evening of the 21st of September, 1875, a compound dislocation of the right knee by a force acting upon the anterior and inferior part of the thigh, and a counter-force acting on the posterior and superior portion of the leg.

I saw him four hours after the occurrence, and upon examination found the lower extremity of the femur driven backward to such an extent that the entire condyles protruded beyond the soft parts at the lower border of the popliteal space. The patella and the head of the tibia were thrown up beyond their natural level, resting on the anterior surface behind the head of the tibia, into the hollow of the femur. The patella had sunk down in front of the joint. The head of the tibia could be easily traced with the finger. The tendons of the extensor muscles were much relaxed, and the limb was considerably shortened. But slight hemorrhage had occurred. The popliteal muscle was of course ruptured, and a portion of it protruded from the opening, which I removed with the scissors. But, strange to say, the popliteal artery was not ruptured, but was found in the intercondyloid notch, completely divested of all surrounding tissue and stretched to its utmost capacity, rendering circulation through it almost if not entirely impossible. I advised amputation, but it was strongly objected to by the family. The patient was then anæsthetized, and, after directing an assistant to make firm counter-extension by taking hold of the thigh, while another, by grasping the foot, produced firm and steady extension, I placed the palm of my left hand beneath the condyles, while with my right hand I forced the leg backward, when the reduction was readily effected, owing, doubtless, to the extensive rupture of the ligaments surrounding the joint. The laceration was then found by measurement to be three inches in its longest diameter. Very little hemorrhage followed the reduction. The wound was sponged off, and simple cold-water dressings applied.

As a precautionary measure, the limb was placed in an ordinary lateral splint, the patient put upon a solid mattress, and one-fourth grain of morphia administered hypodermically. We enjoined perfect quiet on the part of the attendants, and left the young man resting comparatively easy.

Early on the following morning (22d) I found him resting very well; not much pain, although the joint was very much swollen and inflamed. Pulse 104. The wound was carefully cleansed with a Davidson's syringe, great care being taken not to disturb the joint in the least. There was some escape of synovial fluid. The limb was now placed in a splint, by means of which powerful extension and counter-extension could be produced, if so desired. This was done with the intention of forcing the contiguous extremities of the tibia and femur as far apart as practicable. The splint was so arranged that the wound could be cleansed perfectly without in the least disturbing the joint or changing the limb from its extended position. The joint was kept constantly wet with cold water medicated with carbolic acid. A mild laxative was administered. One-eighth grain of tartrate of antimony and potassium in solution was ordered to be given every two hours.

On the 23d, the pulse 102 per minute, hard, and bounding to the touch. Inflammation and swelling somewhat increased; joint very red and hot; not much pain; and, I might add, the patient was comparatively free from pain during the entire recovery. The patient had rested very well through the night, by the aid of one-third grain of morphia. Cleansed the wound as on the previous day. No appearance of synovial fluid. Increased the cold applications, and ordered tincture of aconite root, in doses of five drops every four hours, in addition to the tartar emetic.

On the 24th the pulse was 86 per minute, rather soft, and compressible. A decidedly decreased amount of heat in the joint. Color more natural, but the swelling remains about the same as on the previous day. Patient very cheerful; appetite not much impaired, and bowels in good condition. Dispensed with the aconite. For the following three days the symptoms did not vary.

28th. Pulse 72 per minute. Inflammation gradually diminishing. The wound discharging freely, and presenting healthy granulations. The wound was cleansed every day with the syringe, using as a wash warm water and sweet milk, equal parts, which made a very soothing lavatory. On the 10th of October some exuberant granulations were noticed, which disappeared after a few dressings of dry lint. On the 22d of October, one month from

the occurrence of the accident, passive motion was commenced. The joint, previous to this time, had never been moved in the slightest degree, being kept constantly in the extension splint, with just as much extension and counter-extension produced as the patient could bear. Seemingly, no increase in the inflammation was produced by the passive motion. The splint was now dispensed with, and a supporting bandage substituted, the wound being almost healed. Three days afterwards (25th) motion was again produced, and the limb was flexed at almost a right angle, with very little pain to the patient. No adhesions to signify seemed to have formed. On the 29th of October the patient was able to bear half his weight on the affected limb, and to flex the leg on the thigh at a right angle without any apparent difficulty. All this motion did not produce any noticeable increase in the inflammation. Although the patient was disposed to walk about the room merely with the assistance of a cane, I had him procure a pair of crutches and use them for a few weeks, and also retain the supporting bandage for over a month afterwards. I deferred making this report until I could learn what result the summer work on the farm would have upon the injured limb. And at this date he informs me that he has never, since the throwing aside of the crutches, experienced the slightest inconvenience from that knee. The motion in it is perfect, and he thinks the strength is fully equal to that of the uninjured knee. This favorable result and speedy recovery, I think, are due in the main to the absolute quiet maintained by the extension splint.

WEXFORD, PA.

TOBACCO-POISONING, WITH RECOVERY.

BY W. W. VAN VALZAH, M.D.,

Resident Physician, Philadelphia Hospital.

ABOUT 6 P.M., December 23, 1876, I was called to a person lying on the floor, breathing very slowly and stertorously. His pulse was weak, rapid, and fluttering. His pupils were decidedly contracted, and but slightly sensitive to light. There was also complete loss of power of the upper and lower extremities, and no signs of consciousness could be elicited.

Mustard was given, and flagellations of the breast, face, hands, and feet were instituted. Twenty minutes later we gave 15 grains of the sulphate of zinc; this failing to produce an emesis, in twenty minutes 15 grains more were given, and with the desired effect. In the vomited matter, more than two tablespoonfuls of masticated tobacco were found. The diagnosis of tobacco-poisoning was then made.

After thorough emesis, ʒiij of a strong infusion of coffee, 2 grs. pulv. capsicum, and ʒj whisky, were given every half-hour. Under this treatment, which was kept up for six hours, the toxic symptoms gradually subsided.

After recovery the patient stated that he had taken the tobacco to relieve constipation; that nausea, general numbness, profuse sweating, and great muscular relaxation had been produced. He appears to have suddenly fainted and fallen upon the floor while going to bed.

TRANSLATIONS.

SUB-CONTINUED TYPHOID FEVER (*Archives Générales de Médecine*, January, 1877, p. 120).—At the Medical Congress of Turin, Baccelli read a communication on the association of malarial and typhoid symptoms. He admitted that there is either a union of the two fevers or a veritable sub-continued fever due to malaria with the appearances of typhoid: it is to this special morbid type that he gives the name of sub-continued typhoid fever. He rejects the appellation of typho-malarial, proposed in the International Congress at Philadelphia, concluding that we have not, neither can have, in practice, a true proportion established between two acute and grave affections. He defines the sub-continued fever as a fever caused by malarial infection, pernicious in type; and, according to him, every sub-continued fever has a special form which characterizes it. The chief danger in diagnosis consists in the possibility of mistaking it for a true typhoid, from which it is distinguished by a very notable difference. The sub-continued fever has been at the outset a legitimate intermittent, or immediately a sub-continued fever; it soon gives a high temperature (104° F.), and has some other symptoms, less precise and essential, which distinguish it. The accessions of temperature are frequent during the twenty-four hours, so that the writer insists on repeated thermometric examinations during the day, and lays great stress on the difference between having a continued fever and having the fever continually. In conclusion, he says that the disease has not a necessary course, and that prompt, continuous, and abundant administration of the preparations of quinine is efficacious as a mode of treatment. J. B. R.

EMBOLISM OF THE AORTA PRODUCING GANGRENE OF THE LEGS (*Vierteljahrschrift für die praktische Heilkunde*, 1877, i. 35).—Lauenstein had a case, in the Hamburg Hospital, of a woman aged 25 years, who had previously suffered from repeated rheumatic attacks, and who was admitted for acute rheumatism and pericarditis. After the subsidence of these symptoms she was seized with fever, chills, and severe neuralgia of the lower extremities; finally there was cessation of pulsation in both femoral arteries, the vessel in the right limb feeling like a painful rigid cord. The next symptoms were anæsthesia of both legs, loss of warmth, cyanosis, and gangrene. Eleven days after the complete cessation of circulation the patient died with pyæmic symptoms. During the whole course of the disease there existed a changeable blowing murmur at the base of the heart.

By the post-mortem examination there was discovered, at the beginning of the aorta, an aneurism as large as an apple, and in the spleen and kidneys emboli evidently proceeding therefrom. The most important condition, however, was an embolus plugging the aorta just above its bifurcation into the iliacs, which were completely occluded.

The interest of the case centres in the occurrence of aneurism with such severe sequelæ in a comparatively young patient, as well as in the correspondence between the symptoms and the changes found at the autopsy. J. B. R.

DISTURBANCE OF VISION FROM VARIATIONS IN TEMPERATURE (*L'Imparziale*, anno xvi., Florence, November 3, 1876, p. 663).—A glass-blower, aged 26, worked, while exposed to very high temperatures and to the intense light of his furnaces, for eighteen months, when he was attacked with heaviness without loss of consciousness, and paresis of the right leg. A month later there was superadded amblyopia, especially of the left eye, which increased until he had to give up work. There was difficulty in reading because in five minutes the letters became blurred: moreover, the failure of vision was more marked when the patient was subjected to a hot atmosphere. Sensibility was unimpaired, but paresis of both legs and great weakness existed.

While bathing in summer in a river, he discovered that vision was completely restored, and he accordingly continued to take cold baths with momentary improvement of sight. M. Raynaud assured himself many times of this fact, and noted that by cold immersions the patient was able to regain perception of color. Ophthalmoscopic examinations were made before, during, and after the baths, and showed a slight degree of atrophy of the disc in the left eye, and a diminution of intra-ocular circulation under the influence of bathing which appeared as an anæmia when compared with the state that occurred afterwards. The patient subsequently was attacked by scarlatina and varioloid. Cure finally followed, after many remedies had been employed, and the man left the hospital thinking himself fit to go to his usual occupations. The remedial agents used were cold baths, ergotine, iodide of potassium, galvanism, seton in the neck, and sulphur baths; the last appeared to be most beneficial. The author thought the paresis of the extremities depended on insular sclerosis of the cord, despite the absence of other definite symptoms, and felt inclined to accept the hypothesis of an antagonism between the capillary circulation of the periphery and certain local circulations in explaining the action of cold on the visual power. J. B. R.

DISLOCATION OF THE XIPHOID APPENDIX (*Gaz. Hebdom. de Méd. et de Chir.*, January 26, 1877).—M. Polaillon reported to the Surgical Society of Paris a case of luxation of the xiphoid appendix occurring during pregnancy. The woman, who kept herself tightly laced to conceal her condition, while in the seventh month felt a sharp pain in the hollow of the epigastrium. She had to remove her corsets, and then perceived the existence of a little tumor in the epigastric region. During parturition the pain increased and rendered the labor so severe that instrumental delivery was resorted to by the obstetrician.

There existed at the end of the sternum a transverse elevation limited by a hard edge, and the projecting body was movable from before backwards. It was determined to be a complete luxation backwards of the xiphoid appendix. M. Polaillon tried to reduce the luxation, but met with no success: the displacement persisted, and the appendix became fixed in its abnormal position. Finally pain disappeared. This case, taken in connection with two instances of traumatic luxation of the ap-

pendix cited by Malgaigne, makes the third example of this unusual injury. J. B. R.

POST-MORTEM CHANGES IN WHOOPING-COUGH.—At a recent meeting of the Académie de Médecine (*Le Progrès Méd.*, 1877, p. 29) M. Guéneau de Mussy showed various specimens from children who had died during attacks of pertussis. Ganglionary engorgements of the mediastinum were observed, which pressed upon the recurrent nerves. M. De M. also remarked that in persons who had suffered from cough during life he had found the recurrent nerves pressed upon to a greater or less extent. He therefore had come to the conclusion that nervous excitation by compression was the cause of the cough. This theory gained support from the notion long entertained that whooping-cough is an internal eruptive fever. Local lesion of the pulmonary mucous membrane, engorgement of the peribronchial ganglia, compression of the recurrent nerves, attacks of cough,—such was the chain of events. Complete destruction of the motor nerves of the muscles of the glottis would explain those peculiar cases where aphonia occurs subsequent to whooping-cough, as well as the tedious duration of certain cases of pertussis which drag on for months and years.

In the discussion which followed M. De Mussy's remarks, M. Hardy objected—1, that many children die of whooping-cough in whom post-mortem examination reveals nothing; 2, that certain cases are rapidly cured by change of air; 3, that the cough of pertussis is intermittent, while the pressure of the ganglia should be continuous. M. De Mussy replied—1, that ganglionic alterations are not found because not sought for; 2, that intermittence is one of the characteristics of neuralgia generally; 3, that certain medicines quickly quiet the cough, as they quiet neuralgia in other localities. X.

LOCALIZATION OF MOVEMENT IN THE BRAIN.—M. Maurice Raynaud has addressed a note to the Academy (*Bull. de l'Académie de Méd.*, 1876, No. 49) relative to the following interesting case reported by himself on July 21, 1876, to the Société Anatomique. In a phthisical patient there appeared suddenly, three days before death, a paralysis limited to the *upper limb of the left side*, and attacking in this limb the *extensor muscles of the hand on the forearm* almost exclusively. The only lesion observed at the autopsy was a very small focus of red softening developed on the right hemisphere about a meningeal tuberculous deposit. This centre, which was not as large as a five-cent piece, was situated on the *ascending parietal convolution* in the gray substance forming the bottom of the sulcus of Rolando, at a distance of five centimetres (two inches) from the superio-internal border of the hemisphere. This, however, is just the point which, in monkeys, according to Ferrier, is connected with the movements of the upper limbs. Several more or less analogous cases are known; but the peculiarity of this lies in the fact of brachial monoplegia having existed without any other cerebral disturbance, thus showing the direct connection between the cerebral lesion and the motor disturbance. X.

NEW METHOD OF DETECTING SMALL QUANTITIES OF MERCURY IN THE URINE.—Whether or not mercury administered in certain ways, as by inunction, etc., is absorbed into the system, is sometimes a matter of doubt. The following method, devised by Ludwig, is capable, it is said, of disclosing very minute amounts of the drug; and if the same plan, or some modification thereof, can be applied to the detection of mercury in the milk, we shall be in a fair way of solving the question as to whether breast-milk can be used as a means of nourishing syphilitic infants and at the same time administering specific treatment. Ludwig's method is as follows. Half a litre of the urine to be examined is mixed with two to three cubic centimetres of hydrochloric acid warmed to 60° C., and then five grammes of granulated zinc are added, stirring briskly with a glass tube for the space of a minute. By this operation any mercury which may be present becomes amalgamated with the zinc and thrown down. After the solid portions have settled, the mixture is to be thrown on a filter, washed with hot water, and dried in a water-bath. The dried product is placed within a combustion-tube, drawn out at one end, and heated while a strong current of air is passing through the tube. The mercury, if any be present, is volatilized, and collects in the capillary portion of the tube. When the tube has cooled, the capillary end may be broken off, and a grain of iodine placed in one end and volatilized. This, of course, combines with the metallic mercury, and fine ruby crystals of iodide of mercury collect in the upper part of the tube.

In order to prevent any animal products which may be mixed with the amalgam from obscuring the reaction, a spiral of oxidized copper wire may be placed in the tube, between the zinc amalgam and the capillary end, and strongly heated. This will intercept the volatile products of organic combustion, should such be present. —*Wiener Klinik*, October, 1876, p. 313. x.

HYPODERMIC INJECTION AS A LOCAL REMEDY.—Dr. Luton, of Rheims (*Le Mouvement Méd.*, November 18, 1876) has employed hypodermic injections of salt water in the umbilical and other hernias of infancy with marked success. In one case of congenital umbilical hernia in an infant seven months old, six drops of a solution of salt in water, saturated in the cold and filtered, were injected into the subcutaneous connective tissue surrounding the umbilicus at the four cardinal points. A certain amount of plastic inflammation ensued, followed by contraction of the umbilical ring and retrocession of the hernia. No suppuration followed. Two similar cases were likewise successfully treated by the same method. A young man, twenty-two years of age, suffering from varicose tumors of the leg, was successfully treated by means of injections of five drops of a solution of nitrate of silver (1 to 5) into the cellular tissue just below two of the tumors. Periphlebitis ensued, followed by endophlebitis and the formation of a clot (different from the clot of coagulation following injections of iron, etc., in being quite free from risk), which hardened to a cord and resulted in complete cure. x.

TREATMENT OF GRANULAR CONJUNCTIVITIS (*La France Méd.*, 1877, p. 52).—The treatment of granular conjunctivitis should include both the prophylaxis and the therapeusis of this affection. Of course, in large bodies of men, and where the affection is epidemic, prophylaxis assumes the utmost importance. As to treatment, where the granulations are recent, indolent, without inflammatory complication, calomel ointment may be employed,—℞ hydrarg. chlor. mite, centigr. v ad xx (gr. ¾ ad iij); axungiæ, grm. x (℥iiss); or red precipitate ointment,—℞ hydrarg. ox rub., centigr. v ad xx (gr. ¾ ad iiij); axungiæ, grm. x (℥iiss). These may be smeared over the surface of the conjunctiva, occasionally cauterizing the granulations with sulphate of copper. When the granulations are pale and large, the cautery may be used every day or every second day. When the mucous membrane is red and injected, and when the secretion is muco-purulent, nitrate of silver in solution may be employed, —℞ argenti nitrat., grm. i ad iv (gr. xv ad ℥i); aquæ, grm. xl (℥x); or the mitigated crayon. Should papillary hypertrophy coexist, cauterizations with solution of subacetate of lead may be employed. Scarification may also be practised in connection with cauterization by means of sulphate of copper. Where the sulphate of copper is used, the eyes should be frequently washed out with pure water. Some authorities suggest yellow or black wash. (Dr. S. D. Risley, of this city, in a paper read before the County Medical Society, December 27, 1876, recommends a twenty per cent. solution of carbolic acid in glycerin, which he says has given him much more satisfaction than either the nitrate of silver or sulphate of copper.—TRANS.) x.

INFLUENCE OF VARIOUS REMEDIES UPON THE SECRETION OF URINE AND ITS CONSTITUENTS IN DIABETES MELLITUS.—Dr. Julius Jacobs (*Virchow's Archiv*, 1876, v. 67, p. 197), having a case of saccharine diabetes under observation, undertook a series of examinations of the patient's urine in order to ascertain the influence upon its secretion of oxygen inhalations; the same in connection with the internal use of reduced iron, infusion of juniper bark, tannic acid, and ozonized turpentine. Each of these remedies was employed during two weeks. Dr. Jacobs gives the results of his experiments in detail, and concludes with the following condensed table of results:

AVERAGE IN TWENTY-FOUR HOURS.	FLUID INGESTED, CUBIC CENT.	URINE, CUBIC CENT.	SPECIFIC GRAVITY.	CHLORIDE OF SODIUM.	UREA.	SUGAR.
Without treatment...	3707	5870	1030.37	50,713	91,241	38,731
Inhalation of 4500 cc. oxygen.....	5011	7860	1027.85	64,278	102,191	50,206
Inhalation of 20,000 cc. oxygen and iron.....	5743	9034	1030.07	57,257	121,878	61,600
Infusion juniper bark	6347	8627	1030.57	66,955	126,853	71,469
Tannic acid.....	5885	9717	1030.42	55,327	145,476	80,350
Ozonized turpentine.	5957	9588	1029.42	64,663	151,344	66,894

It will be seen by this table that none of the remedies used in this case had the least effect on the progress of the disease. x.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, MARCH 17, 1877.

EDITORIAL.

THE UNITED STATES PHARMACOPŒIA.

IN our editorial of the last issue we tried to show that no necessity exists for the proposed assumption by the American Medical Association of the ownership of the United States Pharmacopœia, and that the practical working of the proposed plan would be to centre the responsibility in one man, as the sole representative of the civil profession of the country, instead of, as at present, in the hands of a committee whose function is unification of reports from all parts of the the continent. As Dr. Squibb would undoubtedly be selected, much interest attaches to the study of his proposed revised Pharmacopœia. In the first place, would such a Pharmacopœia as he proposes be superior to the old? In the second place, is its superiority so evident and so marked that it cannot be allowed to run the gauntlet of a discussion by experts, but must be adopted by a popular assembly, even at the risk of a general anarchy?

Our Pharmacopœia is composed of two parts,—a list of medicines which have achieved sufficient reputation to entitle them to recognition, and a series of formulæ for preparing these for use. Like the British and the new German Pharmacopœia, its idea is that of a code of laws to which obedience shall be given. The United States Dispensatory is an entirely different work: it is an exposition, so to speak, of the laws.

The Pharmacopœia must command obedience, and must be therefore dogmatic, without statement of general facts or of reasons, or of anything but the law itself. The Dispensatory concerns not merely the law, but also discussions as to the defects, virtues, and meanings of the law, of the best methods of fulfilling its behests, of the natural, commercial, and chemical history and of the therapeutic use of the medicines recognized, of the results of overdoses and of the antidotal treatment. It is plain that it must be a work of statement of fact, of reasoning, of personal opinion, of teaching, and can never command or expect obedience such as is yielded to law. From the pharmacist's point of view, it is a book of instruction for those who are not already fully acquainted with the practice of pharmacy; whilst the Pharmacopœia is for experts, who need only the formulæ to enable them to carry out its processes.

It is asserted that the United States Pharmacopœia exists because the Dispensatory does. But the British Pharmacopœia exists without a Dispensatory. It has been asserted by Dr. Squibb that the copyright of the Pharmacopœia is so held that there can be no rival Dispensatory. As this may be widely believed, it cannot be too widely contradicted; and we copy from Dr. H. C. Wood's pamphlet:

"The copyright of the Pharmacopœia is held by the chairman of the Committee of Revision, and is not owned by either the authors or the publishers of the United States Dispensatory. The Pharmacopœia is printed and distributed by agreement through J. B. Lippincott & Co., and probably any separate issue of it, without authority, would be resisted by the Committee of Revision. It partakes, however, of the nature of a public document; it is written for comment, and it is not probable that any court would justify the copyright as preventing such quotation as may be necessary for that comment. Such enforcement of the copyright would be an injustice, and would inevitably lead, as it ought, to a revolt against the authority of the Pharmacopœia. The authors of the United States Dispensatory have never controlled or attempted to control for their own advantage the copyright of the Pharmacopœia. Assuming the right of quota-

tion, they have quoted whatever they deemed necessary for their purpose. In this they have done no more than what has been the practice of almost every American or English writer upon Materia Medica or Therapeutics."

What Dr. Squibb sets forth as his idea of a Pharmacopœia is really that of a Dispensatory. He says it should "examine and epitomize, and record the results of current research, in a form adapted to current use, and to separate the good from the bad." This seems parallel to a legislature substituting for a code of laws a commentary on laws.

Besides converting the Pharmacopœia into a Dispensatory, Dr. Squibb proposes the establishment, under the auspices of the American Medical Association and under the management of their council, of a medico-pharmaceutical annual. Those who have had experience in attempting to get a new medical journal upon a paying foundation must, we think, look with great suspicion upon such a venture. There are, therefore, in the proposed changes of Dr. Squibb two new radical movements, both of them opposed to the practices of the past, and both of them, in our judgment at least, of very questionable wisdom. This being so, it seems absolutely necessary that the matter be freely discussed by experts, and we most sincerely trust that the American Medical Association will refer the whole subject either to a commission of experts especially selected for the purpose by its president, or, better, to the body of experts selected by the profession at large and known as the National Convention for the Revision of the United States Pharmacopœia.

CORRESPONDENCE.

LONDON LETTER.

WE are still having a continuance of the mild weather by which this winter is characterized. The sale of flowers in the streets is unusually brisk, and many shrubs are covered with well-developed buds. The consequence of the mildness has been that there is an unwontedly small amount of pulmonary disease about. Fixed colds have been far from frequent; and it will be interesting to observe how far this will be found to affect the number of cases of phthisis in its early stages which will present themselves at the hospitals in spring. It would appear that in a large number of cases there is a history of a severe cold about the New Year. This is apparently shaken off, but in a month or two the patient finds himself losing flesh, sweating severely at nights, and troubled with an exasperating hacking cough with very little expectoration. On examination, one or other lung will be found to be dull and resistant to percussion, the respiration in that part to be deficient, jerking, with prolonged expiration, and, less frequently, pronounced râles.

The tendency of such a case is undoubtedly to become tuberculous if the assimilative powers are defective or the salts of the body are drained away in the sweats. In either case there is a deficiency in the body of a very vital element in food-nutrition, and if the condition is not remedied it soon proceeds from bad to worse, and the solidified lung breaks down, a periodical hectic comes on, and the patient swims for his life. The cough which is set up reflexly is unequal to the removal of the irritating masses until they have softened down throughout their structure and have ulcerated sufficiently round their edges to perforate a bronchial tube and thus to be expectorated. This forms a time of grave danger, and, if survived, is followed by a period of disturbed health of greater or less duration, until the cavities so formed assume a chronic condition, either by their walls falling together or becoming covered with a lining membrane. One of the most interesting points in connection with phthisis is its relations to these inflammatory conditions of the apices of the lungs. We are all familiar with the fact that acute inflammation of the lungs involves, in the majority of cases, the lower lobes, less frequently the middle, and very rarely, if ever, the apices of the lungs. It is stated that the first stage of this apicial consolidation is that of bronchitis, and that this extends through the walls of the bronchial tube and excites cell-growth in the lung-tissue; but then bronchitis is infinitely oftener found in the middle lobes than at the apex. Amidst the many workers at phthisis it seems unfortunate that no one devotes his attention to the question of why the apices are the parts selected and the disease spreads from above downwards, as it does in this form of disease. The practical value of the recognition of these causal relations of phthisis is the necessity for physical examination of the lungs after severe colds, and if there is found this consolidation then to set to work and leave no stone unturned to improve the patient's general condition, and to prevent that deterioration of the general health which is liable to follow, and which

causes, in its turn, the lung-changes to take on a malign aspect.

In continuing his Lettsomian Lectures, Dr. Wiltshire has described the different forms of *hemorrhage* from the *female generative organs*, his last lecture being engaged with the treatment of the different varieties of these maladies. A rare and very troublesome affection is that of hemorrhage from the ruptured hymen of a bride who is the subject of hæmophilia, or of the hemorrhagic diathesis. It appears hæmophilia is rare in women, being in the proportion of one to seven in males, but that when it is present it constitutes a very annoying, if not even dangerous, condition to the bride just commencing her wedding-journey. Instances were given where very grave hemorrhage was the result of the completion of the marriage-rite. The use at first of ice and astringents, alone or combined, was advocated, and afterwards of such measures as involved the exposure of the patient only when they became absolutely necessary. Dr. Wiltshire insisted that in cases of uterine hemorrhage it was desirable to commence by carefully looking for every other cause of it than disease of the womb itself. It was much too common to assume in such cases that the loss must have only a local cause, and other sources were not always sufficiently carefully eliminated. The tendency of specialism to narrow the view was often urged, but he did not see why the special study of a subject would not rather enable it to be seen in wider relationships. He then pointed out the different forms of the truly menorrhagic flow, with their appropriate treatment. He laid much stress on the treatment of the patient during the interval and then during the time of the flux, each of which he declared to be equally important. He also laid special stress on the desirability of exhibiting vegetable and mineral astringents in free quantities a day or two before the anticipated flow came on. He advocated the use of iron in those cases where the patient is anæmic and pallid; if necessary, abandoning the chalybeate for mineral astringents and ergot at the time of the flux. In cases of menorrhagia in the plethoric, he did not think iron indicated, and preferred a cooling regimen, with the use of astringents and sulphate of magnesium. In those cases of menorrhagia, chiefly occurring in the young, which depend upon ovarian excitement, the ordinary measures are of no use, and full doses of bromide of potassium or ammonium are to be resorted to. The unloading of the pelvic viscera by full doses of aloes was recommended in both these latter forms. The subject of internal hemorrhages and the formation of pelvic hæmatocele were not touched upon, for want of time.

The subject of *opium-taking* is one of considerable attraction, and, as diversities of opinion exist about the effects thereof, it may not be uninteresting to your readers to know what is thought on the subject by Dr. Macartney, who has risen so high in the Chinese service. Though he has for many years abandoned his profession, he still takes much interest in medical subjects. As to opium-smoking, he admits its direful effects upon those who give way to it, just as in the case of alcohol. If the smoker be a poor man, whose earnings all go in that direction, and who is in consequence insufficiently fed, then the evil effects are soon apparent. But in other cases, where the individual is well fed and in comfortable circumstances, the daily pipe does not seem to be followed by evil consequences. The craving for it at the accustomed hour is exceedingly strong, indeed irresistible, but that is all. The pipe is taken, a delightful snooze follows, and the matter ends. It appears, however, that, whatever may be the effects upon the imagination so produced, the Chinaman does not attempt to transact any business when under the influence of the drug. He knows better than that. In this respect opium again resembles alcohol, and the pipe is resorted to after a successful bargain, as is the bottle of fizz in Western lands. He also quite corroborates the statements of Norman Chevers and others as to the ease and safety with which abortion is procured amidst the Chinese in common with other Eastern nations.

The Pathological Society has had a great discussion on *visceral syphilis*, which, if it has not yet brought forth anything absolutely new, has at least cleared the ground and displayed what is already known. The discussion, which has occupied already two evenings, has been illustrated by numerous microscopical preparations, sections, etc., drawings, preparations of the coarser anatomical lesions, etc. The first subject introduced was that of enlargement of the spleen in syphilitic children. It was stated by Dr. Barlow, who was corroborated by Jonathan Hutchinson, that in such children great enlargement of the spleen was very common. It caused no apparent disturbance, and in time disappeared entirely. The subject of the syphilitic affections of arteries was then brought up, and much interesting information was afforded by different speakers. The résumé of it all is something to this effect. There is a diffuse cell-growth around the vessel, including its external coat and the adventitia, sometimes of a nodular character, as it were of small gummata. Then there is also a cell-proliferation from the endothelium, which may be underneath the tunica intima like an atheromatous patch, or extend into the vessel, forming a thrombosis. In either case the lumen of the vessel was much reduced, and with that the flow of blood through the vessel. Such were the changes formed in the smaller vessels. There was much diversity of opinion exhibited as to whether in such change there was a special morbid process *per se*, or only the ordinary

atheromatous change, somewhat modified by the presence of syphilis. That the blood-vessels are largely implicated in constitutional syphilis was admitted by all. As to the changes in the larger vessels little was said, though Myers and other military authorities were present, and, had the opportunity offered, could doubtless have told of the ravages wrought by syphilis in the aortæ of soldiers. Jonathan Hutchinson asked if changes had ever been recognized by the ophthalmoscope in the retinal arteries of syphilitic subjects. Mr. Hulke stated that he had rarely seen them, and only once in an undoubtedly syphilitic subject. A great deal of evidence was furnished as to the changes induced in the brain and its meninges by syphilis, and also in the roots of the nerves supplying the muscles of the eye, complete fixity of the eye-ball being no rare event. Mr. Hutchinson, with his immense knowledge of the subject and his wonted perspicuity, described the pathology of syphilis "as seen in the living and not in the dead." So readily amenable to treatment is syphilis that he said he was indebted to a mistake in diagnosis for the preparation which he exhibited. This mistake arose from allowing the apparent respectability of the lady patient and her social position to introduce a disturbing lens betwixt his vision and the objective phenomena of the patient. In this case there was disturbance of vision, with fearful headache, for some years before death. The skull was found much thickened, the dura mater was adherent, and the pia mater contained syphilitic masses. There were also convulsions, loss of speech, and ultimately coma, before death. Mr. Hutchinson said that the term "cerebral syphilis" was now much too vague, in consequence of the advance of our knowledge of the subject in recent years. A description was then given of the syphilitic changes in the lung. It appears that there are cell-proliferations around the vessels and the exterior of the bronchial tubes just as in ordinary tubercle, and the question might be raised how far the presence of syphilis modifies the tubercular process as it does other morbid processes, or whether there is a syphilitic phthisis *per se*. As to any special indications of syphilitic disease, it was stated that in syphilitic disease the apex is not the part affected, but rather the roots of the lungs and the middle lobes. Syphilis, too, is ever associated with fibroid rather than tubercular changes, and syphilitic growths do not undergo caseous changes, usually at least. The discussion, unfortunately, gave no indications how syphilitic disease of the lungs and other viscera was to be distinguished from other like changes. The history had to determine the question until post-mortem examination settled it finally, so far as the patient, at least, was concerned. Certain it is that a chronic pneumonia is not rarely found in syphilitic subjects, and that it clears up under mercury and iron much more speedily than do other forms of chronic pneumonia under tonics, cod-liver oil, etc. The practical upshot of the inquiry so far is this: there are various internal changes to which the subjects of syphilis are specially liable, but there are no pathognomonic indications furnished, and the treatment is to be mainly directed by the general history of the case.

It seemed, apropos of this discussion, not out of place to visit the Dreadnaught Hospital, at Greenwich, for sick sailors of all nationalities, and learn what the officials there had to say about visceral syphilis. It is notorious that sailors go on board ship suffering from primary syphilis in its severest forms, and often the ship sails away and for months they either have no treatment or only that of the captain, so that there is furnished an excellent opportunity for the system becoming thoroughly infected. Under such circumstances, then, it might fairly be expected that the Seaman's Hospital would be rich in experience of visceral syphilis. Such, however, turns out not to be the case; and the resident surgeon informed me that he had encountered but one syphilitic liver in an experience of six years. Other forms of syphilitic disease of the viscera were equally rare; so that apparently there must be something about the surroundings of the sailor which exercises an ameliorating effect upon acquired constitutional syphilis. Much, too, depends upon the diathesis of the individual who contracts syphilis as to its ravages, and also as to passing conditions, such as sustained inebriation, partial starvation, overwork, etc.

The Seaman's Hospital at Greenwich is rarely visited by American students of medicine; and yet it is well worth a visit. There are numerous interesting cases always to be found there; while the resident surgeon is one of the most courteous and obliging of gentlemen, and is always willing to give himself trouble to show visitors all that is to be seen. The hospital also furnishes practically unlimited supplies of material for operative surgery, being much better off in that respect than any other institution in or near London. Classes for such purpose are conducted by the resident surgeon, who is also a competent teacher.

A pleasant sail down the river, an hour or so of operations, two or three interesting cases of accident or disease to be seen, ought to form a programme for an occasional a'ternoon a week, well worthy the attention of American students in England. Amidst the cases in at present is one of a severe smash of the right side of the forehead. The skull is driven in extensively, and there is a large internal wound, which bled freely at the time. Shortly after the shock the man recovered consciousness, and, though not very bright, converses rationally with his wife about his affairs, distinguishes clearly the names of children, and, altogether, seems little affected by the smash

as regards his intellectual powers. This case corroborates the view now held, that the left side of the brain is the "driving half," and that the right side occupies a subordinate place.

The Hunterian oration at the Royal College of Surgeons was delivered this year by Sir James Paget, whose oratorical powers are so well known. The attractions thus furnished were supplemented by the presence of the Prince of Wales, the Dukes of Argyll and Westminster, Mr. Gladstone, Professors Huxley, Tyndall, etc. The room was crowded to overflowing some time before the oration commenced, and many of the leading members of the profession were present. The ornate sentences, the graceful thoughts couched in rounded periods, brought forth repeated applause as the orator proceeded. He first alluded to the presence of the heir-apparent, as showing the advancing condition of the professional status; and then, after giving a subtle analysis of Hunter's character and the scope of his work, in its almost limitless bearings, he referred to the recent death of Sir William Fergusson, Sergeant Surgeon to the Queen. He spoke of his cool yet swift manner of operating, his imperturbable self-possession, the keenness of his eye, the strength and dexterity of his lissom fingers, which combined made him the greatest operating surgeon of his day. He also stated how from his genial manner, his humorousness, and his bearing, he was as popular with the public as with the profession. These compliments to his great rival in public favor were received with rounds of applause.

Sir William Fergusson was essentially an operating surgeon; while Sir James Paget is sought rather for his opinion, without which few of the wealthy classes have an operation performed. The two, though rival stars, did not conflict. From his early days Fergusson was remarkable as an operator, and in 1831 was already a teacher in the extra-mural school of medicine in Edinburgh. He was thus a well-known man when he first came to King's College, where his illustrious career in London was exclusively run. His contributions to surgical literature were not extensive, and his best-known work is a surgical hand-book, which never held much more than a mediocre position. His name is largely associated with the operation for hare-lip, and with affections of the bladder. He always spoke in markedly Scottish accents, decidedly Doric, which gave a certain charm to his shrewd sentences. He was far from an orator at the best of times; but he possessed other qualities that strongly endeared him to those who came in contact with him. Among these was a dry humor peculiarly Scotch, and, though no *raconteur*, he enjoyed a good story thoroughly.

As an instance of his coolness, it is related that once when operating for the removal of a deep-seated tumor of the neck a large artery was severed and a tremendous gush of blood followed. An assistant promptly thrust his finger into the wound, with the intention of arresting the loss. Fergusson, quite unperturbed, said, "Jist get your finger out of the way, mon, and let's see what it is," and, quietly securing the vessel, went on with his operation. Sir William had been failing for about a couple of years, and last year his death was daily expected for some time,—when, to the great delight of every one, he rallied. On his return from Scotland in October last he looked very well; but, though the winter has been unwontedly mild, he gradually sank. A large crowd of friends, including a great number of the profession, and as many of the officials of King's College as the institution could possibly spare at one time, assembled at the Euston Square terminus to see his remains placed on the London and Northwestern Express for Edinburgh. Thirty-seven years after the young Scotch surgeon, almost without a friend, came to offer himself as a candidate for the chair of surgery at King's College, the profession mustered in force to see all that was left of the great surgical baronet on its way back to the land of his birth, that he might lie beside his kith and kin at West Linton, the family burying-place. Few of the men who "aimed south" to seek their fortune have died so regretted, and withal so universally respected, as the laconic Sir William Fergusson.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, DECEMBER 14, 1876.

THE PRESIDENT, DR. H. LENOX HODGE, in the chair.

(Continued from page 259.)

Amputation of leg after compound fracture causing necrosis of tibia and fibula and disease of ankle-joint. By Dr. T. B. REED, for Dr. REYNOLDS.

T. M., æt. 39; born in Ireland; occupation, gardener; was kicked by a horse thirteen years ago, causing a depressed fracture of the tibia of the right leg in the lower part of its middle third, and a compound comminuted fracture of the fibula, about the same point.

The wound remained open nine months, and the tibia was then cut down on and several pieces of dead bone were removed (parts of the fibula) by Dr. Packard, after which the leg was entirely healed in three months, since which time he was entirely free from pain until three years ago, when he began to have severe pain in the right ankle, which he supposed was rheumatism, and for which he was treated for some time. Afterwards he was treated in the Episcopal Hospital for periostitis.

Receiving no relief, he left the hospital, and was then under the care of Dr. Bolling, who consulted Dr. Hodge. Dr. Hodge cut down on the lower end of the tibia, giving vent to confined pus. This was followed by four days' freedom from pain, after which it returned and was more severe than ever before. Dr. Hodge was again called, and advised sending him to the Presbyterian Hospital. He was admitted April 19, 1874. The leg was poulticed for a week, when Dr. Hodge cut down again to the lower end of the tibia, and sawed deeply into it with Hey's saw, and at the same time removed about one inch and a half of the internal saphenous nerve, just above the internal malleolus.

This gave him immediate relief, and after remaining in the house forty-two days he was discharged cured.

He remained free from pain or any symptom of disease until about the 1st of September, 1876, when he fell and sprained the same ankle. This was followed by pain of an intermittent character, which continuing to get worse, he again went to Dr. Bolling, September 12, who consulted Dr. Hunt, and again his disease was pronounced periostitis. The limb was painted with iodine for two weeks, and he then came into the Presbyterian Hospital, unimproved, September 26, 1876. At this time there was some redness of the skin, and he complained of severe pain, which was worse at night.

September 30, 1876.—The leg was blistered over the painful part; was followed by abscess, which opened and was found to lead into the tibia at a point two and a half inches above its lower end. The limb was then poulticed. Following this he experienced some relief, but soon began to get worse, and, being unimproved, was again blistered, November 12, over the front of the ankle. This was followed by a large abscess over the internal malleolus, which was opened November 27, evacuating a large quantity of pus followed by considerable hemorrhage. This gave him temporary relief. He again became worse, and in a consultation of the surgical staff of the hospital, December 9, it was decided to amputate the leg. The operation was performed by Dr. Reed, the amputation being made in the upper part of the middle third.

Examination.—The skin is found to be firmly adherent to the tibia in several places, being the cicatrices of his original injury and of more recent abscesses. There is an opening through the skin and into the tibia about two and a half inches above its articular margin. Below, just over the end of the tibia, there is a large, irregular ulcer, communicating on the inner side with the sac of the last abscess over the internal malleolus, and on the outside leading down into the joint.

Tracing down the internal saphenous nerve, it is found to be hypertrophied, and at a point three inches above the malleolus it spreads out into a broad fan-shaped expansion of firm fibrous tissue, which being dissected up about an inch is found to be firmly attached to the deep fascia; below its continuity is lost or destroyed by the abscess over the malleolus. The internal saphenous vein is found to lead into the sac of the abscess, the end being open.

The whole anterior edge of the lower end of the tibia is necrosed, opening into the cavity of the bone, and communicating with the opening above. The interior of the bone is diseased about one inch above the upper opening, or three and a half inches above the lower end of the bone. Several points on the articular face of the astragalus, and its whole anterior edge, corresponding to the diseased part of the tibia, are necrosed. There is also some necrosis of both the tibia and fibula at the articulation.

Dr. HODGE said that he had seldom seen any one suffer more pain than this man did before the operation by himself two and a half years ago. After sawing deeply into the tibia and removing a section of the internal saphenous nerve, the patient was free from pain and could do active work until last September. Since then all this destruction of bone must have occurred.

Extensive ulceration of the small intestine, following obstruction of the bowel. By Dr. R. G. CURTIN, for Dr. JAMES F. WILSON. History by Dr. WILSON.

E. M., aged 38 years, the mother of six children. At the commencement of her last illness she was about seven months pregnant. She had had no unusual symptoms prior to those of obstruction, which presented themselves on the 13th of September, 1876. These were obstinate constipation, stercoraceous vomiting, and pain in the right iliac region. These symptoms increased until the 17th of September, when she had a premature labor, after which the symptoms of obstruction were immediately ameliorated. The next day she had a small stool, although the vomiting was not so severe, but still continued. She would retain food for several days, then the vomiting would be frequent for a day or two. The bowels were quiet, but not confined. Pressure in the epigastrium caused her intense pain. These symptoms continued. She grew weaker and weaker. Emaciation became extreme until the 12th of December, when she died. She had complained of very little pain in the lower part of the abdomen for two months before her death.

Post mortem.—All the organs were pallid, but otherwise apparently healthy, except the small intestine, which was found to be in a state of ulceration for about eight inches, the ulceration commencing about twelve inches above the ileo-cœcal valve and encircling the whole intestine. At the upper and lower end of the ulceration the intestine was very much contracted, so that it was with difficulty

that the end of the little finger was passed through these constrictions. The ulcerations presented very much the appearance of those of dysentery. Peyer's patches above and below the ulceration were not affected. At several points the ulcers were almost entirely through the intestine, and the peritoneum at these points was adherent to other portions of the intestine.

She had had at no time any symptoms of dysentery. Probably the amelioration of the symptoms following labor could be accounted for in this way. The uterine tumor, rising upwards, bent the intestine on itself at the point of constriction, and thus prevented the passage of the contents of the bowels.

Cystic disease of broad ligament, ovary, and fibrous tumors of the uterus. By H. LENOX HODGE.

The patient from whom these tumors were removed was 46 years old, and had suffered from them for three years. She was first tapped in March, 1876. Since then she has been tapped many times, and the cysts once injected with iodine; but ovariotomy was not done, on account of extreme prostration since she came under my care. The fluid removed looked like starch-water, had a specific gravity of about 1008, and contained little or no albumen. Microscopical examinations of the fluid have been made by Dr. Tyson and by Dr. Richardson, who will report the result of their examination. Fluid from these cysts was exhibited to the Society several weeks ago, and its peculiarities commented upon.

Both ovaries are enlarged. The left was bound down by adhesions behind the uterus, and presents hemorrhagic marks upon its surface. The patient had expected her menses about three weeks before her death; but they did not appear.

The right ovary is about as large as a walnut, and contains a thick grumous substance of a brown color.

The mass of the tumor springs from the right broad ligament and is distinct from the ovary. The mass consists of two large cysts filled with fluid described as above, mingled, since the iodine injection, with some pus. These cysts contain in their walls several smaller cysts with semi-solid contents. The tumor on its anterior surface was firmly adherent to the abdominal walls.

The uterus was enlarged about three times its natural size, and contained a number of subperitoneal fibroid tumors, and a small polypus projecting from the external os. This accounts for the tendency to menorrhagia which existed, and is unusual in uncomplicated ovarian tumors.

The liver was found pressed up high in the thorax, its upper surface reaching above the nipple to the fourth rib.

The rest of the abdominal organs were normal, except that the stomach and large intestines were distended with gas.

Dr. JAMES TYSON said he had examined some of the fluid microscopically, at the request of Dr. Hodge, and had found large numbers of the small granular cells,—the so-called "ovarian cells."

Dr. J. EWING MEARS said that he thought the portion opened as the ovary before the Society was really a cyst,—an exogenous cyst. The tumor consists of endogenous and exogenous growths, the latter being upon the periphery and sometimes rupturing into the peritoneal cavity. They are filled with the same fluid as the endogenous cysts.

Dr. HODGE said that this was his own opinion prior to the post-mortem examination, which corroborated the diagnosis in all other respects. Before death, a small rounded tumor was felt above Poupart's ligament of the right side. This was believed to be an exogenous growth from the main tumor. The patient herself said it was the ovary, and it seemed sensitive to pressure. Upon the post-mortem examination it was found to hang like the ovary from the posterior surface of the broad ligament, and bore the usual relation of the ovary to the Fallopian tube. In the opinion of all present at the examination, it was the ovary which had become cystic, and that the chief tumor came from the broad ligament. Since the examination the specimen has lost much of its original appearance, especially by the collapse of this small cyst. This case is interesting not only in reference to the so-called ovarian cell, but also in reference to the presence of albumen in these cystic tumors. The fluid obtained by the numerous tappings contained no albumen, except at the last tappings, and then only in small quantities. This I have observed in other cases, even in a more marked degree,—a tumor which at first possessed all the characteristics of a tumor of the broad ligament, monocystic, containing a very thin fluid, of low specific gravity, clear as spring-water, and without albumen; such fluid returning after tapping, with the characteristics of an ovarian fluid, being thick, of high specific gravity, dark color, and loaded with albumen, thus suggesting that the disease has extended from the broad ligament to the ovary. This may have occurred in this case.

The specimen was referred to the committee on the "Ovarian Cell," with a view to determining the nature of the portion which was found at the post-mortem examination "to hang like the ovary from the posterior surface of the broad ligament."

Report of the Committee.

"The growth is a multilocular cyst of the ovary. The small projecting portion on the external surface of the growth was found to be a small, distinct, exogenous cyst, containing fluid similar to that in the parent cyst. Careful examination did not reveal the presence of any portion of normal structure of the ovary."

"Dec. 28, 1876."

REVIEWS AND BOOK NOTICES.

A Practical Treatise on Diseases of the Skin. By Louis A. Duhring, M.D., Professor of Diseases of the Skin in the Hospital of the University of Pennsylvania; Physician to the Dispensary for Skin Diseases, Philadelphia; Author of "Atlas of Skin Diseases," etc., Philadelphia, 1877.

Amidst the gallimaufry of modern medical literature, trustworthy treatises upon Dermatology have long been conspicuous by their absence. Extended experience, accurate observation, sound judgment, and the ars docendi, the four cardinal virtues of the medical author as he should be, are but rarely found united in one individual. At last, however, we have a practical treatise, so full and systematic, so sound and sensible, and so scientifically exact, that we unhesitatingly recommend it as the text-book in Dermatology for students and practitioners in America. There have been, it is true, valuable treatises—now antiquated; there are valuable modern works—too extended for the student's time, means, or needs; there are concise and practical manuals—in other languages; there are excellent translations of these, and there are valuable English hand-books; still we have not, as yet, possessed exactly what is required; for the former do not give to the treatment quite the amount of space demanded by practical physicians, while the latter are dealing with an essentially different material, unlike surrounding conditions, and with more or less dissimilar types of the diseases themselves. Dr. Duhring's treatise is abreast of modern investigation, is condensed within the limits of the needs of the general practitioner, is adapted, as to treatment, to the requirements of the medical profession in this country, and is withal so thoroughly complete in itself, while at the same time exceptionally clear, that the possessor of this volume will for years to come require no other in this branch of medicine. And to all this may be added that it possesses several novel and specially distinctive features of its own. Among these we would call particular attention to:—I. The minuteness of detail in the descriptions of the individual lesions, for upon accuracy in description the author lays great stress. Thus he contends that "it is not enough to say that an eruption consists of a group of pustules, these must be separately studied and their characters described." II. The illustrations of the structure of the normal skin and of the parasites, the work of Dr. Arthur Van Harlingen, whose admirable original drawings constitute an agreeable variation from the familiar stereotyped illustrations of other works. III. The adoption of the classification of Hebra, founded on pathological histology, this being the first work on Dermatology in the English language based boldly upon the German system of classification. IV. The avoidance of theoretical or unsettled points and of useless or obsolete terms. V. The omission of cases, which would have been out of place in a book of this description.

The scope of the work is to furnish a handbook for students and general practitioners, and its key-note is struck in the first lines of the preface, "a concise, practical, and useful treatise;" the history of Dermatology and its constituent parts is therefore very properly omitted. The subject matter is otherwise well arranged. The volume contains 618 large octavo pages, and consists of two parts, the former devoted to "General Considerations," Anatomy, Symptomatology, Etiology, Pathology, Diagnosis, Treatment, Prognosis, and Classification; the latter to "Special Diseases," under nine separate classes, Disorders of Secretion, Hyperæmias, Exudations, Hemorrhages, Hypertrophies, Atrophies, New Growths, Neuroses, and Parasites.

Part I. is ably and carefully handled. No part nor appendage of the skin is neglected anatomically. The remarks upon "external causes," under Etiology, have a special practical value. The chapters on Pathology and Diagnosis are well arranged and clearly expressed. That devoted to treatment is judiciously considered. A few more words as to the importance of what all know and each neglects—hygiene—might possibly have been of value. Under "arsenic" the folly of the use of this drug in all cases of disease of the skin, as routine practice, is most properly alluded to, while under "caustics" the weakness of nitrate of silver, which hardly deserves the name of caustic, and the dangers from the over-use of caustic potash, might have been with propriety even more forcibly stated. The "classification" is excellent, based, as it should be, upon Anatomy and Pathology, and clear and sharply defined in its groupings. The twelve classes of Hebra are reduced to nine, the anæmiæ, pseudoplasmata, and ulcerationes not being regarded as distinct classes.

In Part II. the schema, consistent, simple, and good, of the separate lesions, is as follows: Name; Synonyms; Clinical Definition; then, Symptoms; Etiology; Pathology; Diagnosis; Treatment; Prognosis; all showing accurate observation, diligent study, soundness of method, good judgment, practical common sense, and a skill based upon actual experience. In Class I. a little more space might have been with propriety devoted to the views of the antagonists of the theory of the sebaceous nature of Molluscum. Nor will this lesion need a qualifying adjective to distinguish it from the neoplasm of Class VII. if for the latter the anatomically preferable designation of Virchow, Fibroma Molluscum, be substituted for that of "Molluscum fibrosum." In this class Sudamina is regarded as the Miliaria Crystallina of Hebra, while

Miliaria, Class III., is considered identical with the Sudamina of that author. In Class III. the term Lichen Planus is adopted in accordance with the views of English writers, and is made to include the Lichen Exudativus Ruber of the Vienna school. To this class is added also the lesion Impetigo Contagiosa. In Class V. we find Dermatolysis separated as a distinct lesion from Fibroma Molluscum. In Class VI. the "Keloid of Addison," from *kelis*, a burn, classed by Kaposi as Scleroderma, is described under Morphœa, and this last is distinguished from the anæsthetic spots of Leprosy. In Class VII., the Cheloide of Alibert, from *chele*, crab's claw, is divided into spontaneous and cicatricial, instead of, as formerly, into true and spurious. Here also is placed Pellagra, which we must consider as belonging more properly to the exudative erythemata, while Frambœsia is, and with more justice, annexed from the class of Hypertrophies in the German nomenclature. Here may be found introduced, as a new but definite cutaneous lesion, Neuromata of the skin, for our knowledge of which we are largely indebted to the investigations of the accomplished author. In Class IX. we notice as an improvement in nomenclature, already generally adopted by Dermatological specialists, that the various forms of vegetable parasitic disease are united under the title Tinea as the substantive, the botanical and consequent clinical variations of type being designated by qualifying adjectives.

Generally considered, we note the absence of the contagious inflammatory processes, Variola and Vaccinia, Scarlatina, Morbilli and Rubeola [Rötheln], which might well have been touched upon even though not considered at length. The chapter upon the Syphilodermata is especially carefully considered, and Scrofuloderma, often neglected by Dermatological authors, finds also a place. Moreover, the superiority of this nomenclature over that of the patronymical forms in "ide" is self-evident. Under Eczema the remarks upon differential diagnosis deserve close attention. Prurigo is most justly considered as a disease by itself, of distinct and well-characterized type, and is distinguished from Pruritus, itching, which is not a disease but a mere nervous symptom, and from Phtheiriasis, or the results of pure external irritation due to lice and scratching. In England these three totally distinct processes are hopelessly confounded, and much confusion also exists in regard to the distinctions between Psoriasis, Elephantiasis Græcorum and Elephantiasis Arabum, upon which distinctions the author might have perhaps advantageously laid even more stress. As individual points we approve the grounds held in regard to several questions, viz., the distinction between the sthenic or exudative form of Acne and the cachectic form with comedones; the fact that Rosacea, or dilatation of capillary blood-vessels, may occur alone or precede the formation of Acne; the non-parasitic origin of Alopecia Areata; the non-contagiousness of Leprosy; the existence of Pityriasis Rubra as a distinct disease differing from Eczema Squamosum; and the adoption of the term Lentigo in preference to the etiologically false one Ephelides. Under Acne the practical point of the incompatibility of preparations containing sulphur with those containing mercury or lead might well have been touched upon. We should have been pleased also had the metric system been adopted in the prescriptions given.

As a whole, however, the volume is so consistently good, and so smoothly and harmoniously rounded in its entirety, that it lacks salient points upon which to attach adverse criticism. The style is clear and interesting, the paper, type, binding, and proof-reading are unexceptionable, and the book concludes with a bibliography and a carefully prepared index. It has our honest and hearty approval and commendation. E. WIGGLESWORTH.

A COURSE OF ELEMENTARY PRACTICAL PHYSIOLOGY. By M. FOSTER, M.D., F.R.S., Fellow of, and Prælector in Physiology in, Trinity College, Cambridge. Assisted by J. N. LANGLEY, B.A., St. John's College, Cambridge. 12mo, pp. 244. London, Macmillan & Co., 1876.

The increased attention which has of late years been paid to Practical Physiology and Histology has resulted in the preparation of a number of useful manuals, which are published as guides to the worker in these departments. Among the very best of these is the little book under consideration. Its peculiarity is that in it histology and physiology are closely combined, instead of being separated into two or more distinct courses. Although the author, according to his own statement, stands alone in this method, continued experience makes him more and more convinced that the plan he adopts, though troublesome, is the safest one. In it, as far as practicable, the anatomy and histology of each tissue or organ are studied, and then without delay the physiology; "so that the student may, in learning what is known concerning the action of the part, form an opinion of the relative importance of the structural details." We quite agree with the author, where time will admit the length of courses which are necessitated by such a method, which requires from fifteen to eighteen weeks, and are satisfied that any student who works through the lessons of this volume will have a thorough knowledge of the elements of histology and physiology. We would strongly recommend its adoption as a guide in the physiological laboratories which are springing up in connection with many of the medical schools of this country. It is conveniently bound in flexible covers, and admirably adapted to the purpose for which it is intended. J. T.

CYCLOPÆDIA OF THE PRACTICE OF MEDICINE. Edited by Dr. H. VON ZIEMSSEN. Vol. VI.—DISEASES OF THE CIRCULATORY SYSTEM. By Prof. ROSENSTEIN, of Leyden; Prof. SCHROTTER, of Vienna; Prof. LEBERT, of VEVAY; Prof. QUINCKE, of Berne; Dr. BAUER, of Munich; Dr. STEFFEN, of Stettin; Prof. VOGEL, of Dorpat; and Prof. WAGNER, of Leipsic. ALBERT H. BUCK, M.D., Editor of the American Edition. New York, William Wood & Co., 1876.

The present volume of Ziemssen's work embraces also matter which should have been included in volumes vii. and viii., comprising the chapters on whooping-cough, diseases of the lips and cavity of the mouth, and diseases of the soft palate. Perhaps the most important articles in the volume are those by Schrotter, Quincke, and Bauer on the diseases of the cardiac substance, the arteries, and the pericardium, respectively. Some of the articles, notably that of Vogel on affections of the lips and cavity of the mouth, seem to us scarcely to possess a *raison d'être*,—the ground has been, or will probably be, in great part covered by other contributors to the Cyclopædia; and occasionally the articles on some less important topics are so brief as to be very unsatisfactory.

A TREATISE ON HERNIA, WITH A NEW PROCESS FOR ITS RADICAL CURE, AND ORIGINAL CONTRIBUTIONS TO OPERATIVE SURGERY, AND NEW SURGICAL INSTRUMENTS. By GREENSVILLE DOWELL, M.D., Professor of Surgery in Texas Medical College, etc., etc. Philadelphia, D. G. Brinton, 115 South Seventh Street, 1876.

Professor Dowell, in a work of about two hundred pages, has given a brief description of the many forms of hernia, together with the various plans of treatment, palliative and curative, that have been devised for its relief by different operators.

In addition to the subject of hernia, about one-third of the book is devoted to an account of several new surgical instruments that have been invented by the author.

The portion of the monograph on hernia that is of the greatest interest is that which contains a short explanation of the author's method for the radical cure of hernia.

In this method the serous surfaces at the neck of the hernial sac are brought in apposition by subcutaneous metallic sutures. These sutures are allowed to remain in position for a period varying from five to eight days, the indication for their removal being the amount of irritation excited by their presence. The chief risk attending this operation is that of peritonitis, which may become general. Of course, local inflammation of the opposed surfaces of the sac is essential to the success of the operation, and by judicious treatment the inflammatory action can be prevented from extending to the general peritoneal surface. For some time after the sutures have been removed, it is necessary that the recent adhesions at the neck of the sac be supported by a soft compress, retained by a spica of the groin, or by a truss with a soft pad.

The writer of this notice has had an opportunity of repeating this operation three times in cases of complete indirect inguinal hernia.

The immediate result in each case was highly satisfactory: what the ultimate result will be, time only will enable us to determine.

Professor Dowell reports sixty-eight cases operated on by himself since 1859, with only eight failures, and no fatal results.

The only instrument used in this operation is a semicircular needle, five inches long, spear-pointed, with an eye near one extremity.

The new surgical instruments described by the author are of very little practical value, and probably will never be generally used by surgeons. Their invention to meet a variety of indications shows that the author possesses more than ordinary mechanical ingenuity, a talent of great service to the surgeon.

The work contains quite a large number of illustrations of a very poor character, especially those designed to aid the reader to understand Professor Dowell's method for the radical cure of hernia. C. T. HUNTER.

GLEANINGS FROM EXCHANGES.

THE SIGNIFICATION OF AN UNRUPTURED HYMEN IN PREGNANT WOMEN (*The Medical Press and Circular*, December 27, 1876).—Prof. Braun, of Vienna, arrives at the following conclusions in connection with this subject:

1st. An unruptured condition of the hymen cannot alone be regarded as a sign of virginity.

2d. The hymen may possess so much elasticity that a not very voluminous organ may penetrate the aperture without leaving any trace of its presence in the vagina, so that the individual may be regarded as a virgin in the anatomical but not in the gynæcological sense.

3d. Various cases show that for impregnation to be produced it is not requisite that penetration of the vagina should take place, the deposition of semen within the vulva being sufficient.

4th. The accumulated blood seems to be more favorably discharged by spontaneous openings than by operative procedure.

5th. An *error loci* may occur, the urethra taking the place of the vagina as a channel for copulation.

6th. An imperforate hymen cannot be regarded as a preventive of delivery.

These conclusions are based upon a series of clinical observations which place them beyond dispute.

THE TOPICAL ACTION OF REMEDIES (*The*

Practitioner, January, 1877).—Mr. G. R. Sasquet at the conclusion of a paper on the above subject sums up his results as follows:

1. A remedy applied to the surface of the body may be absorbed, and may then produce certain direct effects upon the tissues of the part. Probably the local effects of mercury and iodine are examples of this kind of action; perhaps, also, the pustulation of tartar emetic and croton oil is due to an eliminative irritation of the sudoriparous glands.

2. Paralysis of the terminal branches of the motor and sensory nerves and the arrest of secretion by belladonna may be explained by a direct action upon the nerve-fibre of the part.

3. Hyperæmia, inflammation, and all the more complex perversions of nutrition produced at the seat of application by remedies, are due to reflex vaso-motor action, usually of the kind at present called inhibitory.

4. "Counter-irritation," and all the other secondary or distant effects of the local application of remedies, are due to reflex vaso-motor action, excited by the primary effect of the application and propagated by means of the nerves.

5. In some cases at least these secondary effects tend to reproduce in kind the impression primarily produced at the seat of application. According to the commonly received hypothesis of inhibition, we should expect this law to apply only to such instances as are mentioned above under No. 2, and not to such local results as are due to reflex vaso-motor action.

A NEW THEORY OF WHOOPING-COUGH.—At the last sitting of the French Academy of Medicine, M. Guéneau de Mussy broached a new theory of the nature of whooping-cough. He considers it an exanthematous fever, the eruption taking place on the mucous membrane of larynx, trachea, and bronchi, causing tumefaction of bronchial ganglia. These ganglia compress and irritate the pneumogastric nerves, producing the characteristic convulsive cough. He assigns the persistence of the cough, after the *pyrexia* has subsided, to the continuance of the ganglionic engorgement. The vomiting that so often accompanies this disease is also assigned to this cause. He supports his theory by the fact that enlargement of the bronchi or ganglia from other causes also produces a convulsive cough analogous to that of pertussis.

EXCISION OF THE ELBOW-JOINT (*Boston Medical and Surgical Journal*, January 4, 1877).—Dr. H. A. Beach reports a collection of twenty-one cases of excision of the elbow-joint operated on at the Massachusetts General Hospital by Dr. R. M. Hodges during a period of ten years. The report is made for the purpose of showing the ultimate and excellent results of excision of the elbow when recovery takes place, and the advantages of a single straight incision in its performance. This method, largely avoiding the cross-cutting of any tissues, allows "the connection of the triceps extensor tendon, with the investing aponeurosis of the arm and forearm, to be preserved almost intact. An attachment for the muscle is thus retained which diminishes, to a certain extent, the loss of power following its unavoidable separation from the olecranon." Transverse incision of the integuments, even though the above-mentioned connection is maintained, is in itself prejudicial to the subsequent motions of the limb, if the wound does not unite by first intention, but cicatrizes by granulation, as it almost invariably does.

Another cardinal point in this operation is the preservation of the attachment of the brachialis anticus muscle. It is commonly stated that this muscle is inserted into the coronoid process. No method of demonstration better displays the absolute fact in regard to this anatomical point than excision of the elbow on the dead subject, which, without dissection, makes plain that the attachment is into the shaft of the ulna and *base* of the coronoid process, abundant room being left between the process and the tendon for the passage of the saw (which should always be started on this side of the bone) and the removal of this portion of the ulna. Experience shows that the extent of fracture permitting an attempt to save the limb by excision seldom reaches a degree which prevents the carrying out of these rules; and it rarely happens that so much of the radius requires removal as to cause any interference with the insertion of the biceps. The great muscles of extension and flexion are thus left in a comparatively undisturbed condition. The amount of bone excised decides to some extent the subsequent mobility. Excision of the articulating surfaces alone would probably in most cases be followed by an anchylosis. Regret might sometimes be felt at not having excised enough, but seldom at having removed too much. The sacrifice should always be at the expense of the humerus, since the limit for the ulna and radius is fixed, as has been stated, by the necessity of preserving the brachialis anticus and biceps muscles.

Of the excisions, fourteen were for injury; of these five terminated fatally, but in none of them was there any reason to think that amputation or expectant treatment would have been followed by any more favorable results. Four of the remaining operations were for disease, and three for deformity: one of the latter resulted fatally from secondary hemorrhage.

The treatment pursued can be briefly stated. The wound was invariably closed with sutures. The arm, after the operation, was placed upon a pillow and flexed at an angle of one hundred and thirty-five degrees, that being the position most comfortable for the patient. Local inflammation, abscesses, pain, etc., were met by active measures based on

general surgical principles. A generous diet was always allowed and encouraged. When the arm was in a state to permit of bandaging, an internal angular splint of tin, broader than usually adopted for fractures, and fitted, as regards length, for each individual case, was applied, and the patient allowed to get up and walk about, the wound being dressed without the removal of the splint.

The time spent in the hospital was not great: one patient remained seventeen weeks, the others an average of about nine weeks. When discharged, the splint was usually dispensed with, and a sling substituted. Passive motion was rarely practised beyond that which came from such use of the limb as patients could be persuaded to make, and a useful arm was seldom obtained before the end of a year from the time of excision.

In twenty-one cases where amputation must otherwise have been performed, this report exhibits fifteen arms preserved, several of them being useful to a remarkable degree, and all of them, except one, retaining motion of the elbow, forearm, hand, and fingers. These excellent results suggest the inquiry whether this operation is not deserving of a broader application. A successful excision always leaves an arm more serviceable than one in which anchylosis has taken place after a bad fracture unaccompanied by a wound. Professor Busch, of Bonn, has twice excised with success the entire joint, for irreducible dislocation of the head of the radius, both pronation and supination being regained. A measure which of itself, in civil practice, so seldom occasions a fatal result, would seem more than merely justifiable in this seemingly trivial but thoroughly disabling accident, in which reduction is often impossible, or, if possible, so rare to maintain.

Forcible Dilatation of the Sphincter Ani in the Treatment of Hemorrhoids (*The Clinic*, November 18, 1876).—Dr. Christofari, in his work on this subject, comes to the following conclusions. Contraction of the sphincter ani plays an important rôle in the production of hemorrhoids. This contraction is much more frequent in hemorrhoidal affections than most writers on the subject think. It produces the constipation and the acute pain which these patients suffer before and after defecation. It exists, too, without pain, and for this should be none the less considered as a cause productive of hemorrhoids. In removing the constriction the physician relieves the painful symptoms which it occasions, and at the same time may treat the diseased parts. The best method to employ is that of forcible dilatation. This proceeding, so simple and so harmless, has succeeded in a very great number of cases.

Sealing of Compound Fractures with the Compound Tincture of Benzoin (*The Medical Record*, January 13, 1877).—Mr. Bryant, of Guy's Hospital, has been treating fourteen consecutive cases of compound fracture by closing the wound as soon as possible after the accident with lint saturated with the compound tincture of benzoin. The results obtained have been almost uniformly satisfactory. In one case, where the injury was produced by the kick of a horse, the fracture was at the junction of the middle and lower third of the limb. A piece of bone projected through the lacerated wound, and there was much contusion. The dresser at once reduced the fracture, and closed the wound with several pieces of lint saturated with the compound tincture of benzoin, and then swung the limb upon suitable splints. No pain or constitutional disturbance followed. When the lint was removed (on the twenty-fifth day) the wound had completely healed and the fracture was united. Three other consecutive cases are given, in all of which good results followed. In the second case the dressing remained undisturbed for twenty-seven days, and on being removed the wound was healed and the bones were consolidated. About three weeks later he left the hospital with a good leg.

The third and fourth cases are much of the same character, in the one instance the dressing remaining in place twenty-six days, and in the other sixteen.

Primary Cancer of the Spleen (*Le Progrès Médical*, September 2, 1876).—Primary cancer of the spleen is a pathological rarity. There are very few unequivocal cases on record; but among them may perhaps be classed one that was brought before the Société Anatomique at its April session. The subject of the disease was a male, 51 years of age, with a history and some of the symptoms of cancer of the stomach. After death, however, the stomach and the whole intestinal tract were found to be healthy; but the spleen and lumbar glands were extensively diseased. The former organ measured eight inches in each direction, was of firm consistency and smooth surface; but on section it was found to be pervaded with firm yellowish-white nodules of cancer, which together far exceeded the amount of parenchyma remaining. Some of the nodules were breaking down in the centre. The lumbar glands were also infiltrated, and formed a lobulated mass around the abdominal aorta. The liver contained a few miliary nodules, and was adherent to the diaphragm, whilst a solitary cancerous nodule was present on the corresponding pleural layer. Other secondary growths were found in the sternum, ribs, and vertebræ. The authors of the communication, while acknowledging the rarity of primary splenic cancer, point out that the disease was more advanced in the spleen than in the lumbar glands,—the only other place in which it could be considered to have arisen; and they particularly insist upon the absolute freedom of the stomach and rectum from the disease. No mention is made, however, of

the microscopical characters of the growth,—an omission of considerable importance, since it is highly probable that it was of the nature of lymphadenoma, in which case the extensive implication of the spleen, as contrasted with the liver, and its association with the tumors, would not be so rare an event as the authors would have us believe.

EXTIRPATION OF THE LARYNX (*Boston Medical and Surgical Journal*, December 28, 1876).—Dr. Maas performed this operation in a case of cancer of the larynx of nine months' duration. Tracheotomy had been performed previously, owing to difficulty of respiration. The various steps of the operation were: incision on the median line exposing the larynx; section of the hyo-thyroid and hyo-epiglottidean ligaments after the larynx had been peeled out from its bed on each side by a periosteum elevator; next, separation from the œsophagus, and finally from the trachea close to the cricoid cartilage. The operation lasted one hour. The wound was plugged with cotton-wool. The patient rallied well from the operation, and on the ninth day was able to leave his bed, but on the twelfth day he had a chill, and died of pneumonia on the fourteenth day. The operation was performed at the residence of the patient. To prevent the flow of blood into the trachea, a footstool was placed under the patient's back, thus directing the flow of blood towards the head. A rubber tube was kept permanently in the œsophagus, for the purpose of feeding the patient, and caused no discomfort. The reporter states that this operation has been performed seven times, with three deaths.

MAISONNEUVE'S CAUSTIC ARROWS (*Proceedings of the Medical Society of the County of Kings, Brooklyn, N.Y.*).—Maisonneuve's caustic arrows consist of one part of chloride of zinc and three parts of flour made into a paste with water and dried in various shapes.

Dr. J. C. Hutchison thus summarizes his conclusions as to the place which they should occupy in surgery:

1. Zinc arrows should be used when the disease, especially if malignant, cannot be taken away entirely by the knife; more particularly if there is a fetid discharge from an open sore, with hemorrhage and pain, which is gradually wearing out the patient's strength, as in uterine and other cancers.

2. If the tumor has more width than thickness, involves the integument, is ulcerated upon the surface, is situated at the bottom of an old wound, and fixed as it were against the bones,—if, in a word, it is not possible to remove the disease without causing a considerable loss of integument,—then the caustic should be preferred.

3. In those patients who absolutely refuse extirpation by the knife, the use of caustic arrows is admissible, even though the skin is sound and the tumor movable and can be removed by the scalpel, so as to leave a wound whose edges can be more or less approximated.

4. When erysipelas, pyæmia, septicæmia, or puerperal fever is prevalent, especially in hospitals, operations should be done with caustic arrows in preference to the knife, in suitable cases.

5. Cauterization, practised as here described, is entitled to occupy a prominent place among our surgical resources.

ON THE INFLUENCE OF SALICYLIC ACID IN TYPHOID FEVER.—Mr. E. A. Snell gave a boy aged 14, who had typhoid fever, salicylic acid in ten-grain doses every four hours. On the twelfth day of the fever his temperature had risen to 103⅘° Fahr., and his pulse to 116; moreover, he was somewhat comatose, his tongue very dry and furred, in consequence of his parents having left off the medicine as he had had four liquid stools. The dose was increased to twelve grains every three hours, and his brandy to three ounces daily. On the following evening (*i.e.*, twenty-four hours after) his temperature had fallen to 101° Fahr., and his pulse to 104; tongue moist and cleaner. He also readily answered any questions put to him. The medicine was then given every four hours, and the boy convalesced.

In another case that presented all the symptoms of a severe attack of typhoid, this drug apparently cut it short.

MISCELLANY.

HYDROPHOBIC COWS.—The *Avenir des Landes* reports a fact which is very rare in the annals of veterinary surgery, and which has occurred at St. Columbie, in Switzerland. Last October several cows were bitten by a dog which was placed to guard them. The herd tied up the poor animal in its kennel, and shortly afterwards it died with complete paralysis of the lower extremities. On the 2d of November three of the cows refused their food. An abundant viscous and adherent saliva flowed from their lips, and at the end of six days they died with well-defined paraplegia. During the course of the disease they made no attempt to bite, nor showed any symptom of madness, except that the presence of a dog excited them to an extraordinary degree. In two months eleven cows died or were killed. The incubation of the disease was twenty-five to thirty days in the first eight, and fifty-six in the three latter.—*Medical Press and Circular.*

THE *Gazette des Hôpitaux* reports the case of a man whose pulse was only 21. The beats of the heart were regular, and, excepting a hydrocele, the man seemed well and jovial.—*Western Lancet.*

THE revised edition of the British Pharmacopœia is announced.

NOT long since, the *New York Medical Record* contained certain editorial censures upon medical journals allowing the use of their columns for the advertisement of quack or proprietary medicines. We pointed out at the time that the *New York Record* was doing exactly what it was condemning, but acknowledged at the same time that the circumstances all indicated a lack of vigilance rather than of good intention on the part of the publishers of the *Record*. Subsequently we received a note from the publisher of the *Record* asking us to point out the offending advertisement. We did so, probably to the satisfaction of both publisher and editor, as we heard no more about the subject, either publicly or privately. We do not often look over advertising columns; but, so far as we have noticed, since that time until the present the *Medical Record* has been correct in its course. It is now our painful duty to call attention to the fact that one of the most prominent positions in the whole advertising sheet of No. 331 of the journal alluded to (March 10) is allotted to the puffing of an avowedly proprietary nostrum. If this be a case of inadvertency, it is gross carelessness, and the editor or publisher of the *Record*, according to our thinking, owes an apology to its subscribers, and a pledge of greater watchfulness in the future. This may seem a small matter to some; but the crevice in the dikes soon widens into a breach, and if the flood-tide of quackery once begins to sweep through the respectable medical press unobserved, general ruin and debauchery seem inevitable. In the present instance the matter is the more serious because in *New Remedies*, a journal published by the publishers of the *Record* and edited by a physician of the same standing as the editor of the *Record*, displayed homœopathic advertisements are set forth with all the resources of the printer's art. The animus on the part of the publishers evidently exists; and it becomes the editor of the *Record* to be vigilant, and the New York profession to aid him by a steady pressure of awakened public opinion in his effort to maintain the purity of its advertising columns.

PROF. LISTER is talked of in London as the successor to Sir William Fergusson at King's College.

THE new edition of the United States Dispensatory will be ready in a few days. Part I. has been revised by Dr. George B. Wood, Parts II. and III. by Dr. H. C. Wood,—in each case aided by Prof. Bridges, of the Philadelphia College of Pharmacy.

DR. LEWIS EDWARDES, surgeon of H.M.S. *Volage*, died recently in ten minutes, from cyanide of potassium, taken by mistake.

THE London *Lancet* records the case of Lady Smith, who died recently in England, lacking only a few weeks of being 104 years of age. She was the widow of a president of the Linnæan Society, but had never had children. She had enjoyed good health, except occasional attacks of gout, till within a few months of her death, which was produced by acute bronchitis.

DR. GURDON BUCK, of New York, died of uræmic coma, after a lingering illness, March 6. He was born May 4, 1807. Although a bold and successful general surgeon, he will be chiefly remembered for the improvements which he has made in autoplastic surgery and in the treatment of fractures: probably above all other of his additions will be valued the block-and-pulley system of treating fractures of the thigh.

NOTES AND QUERIES.

MR. EDITOR,—The writer hopes you will give the following explanation space in your "Notes and Queries," as you did the article referred to below.

Under the head of "Notes and Queries," in the *Medical Times*, page 168, January 6, 1877, occurs an article censuring a druggist for refusing a half-ounce of brandy to a lady who was in a fainting condition, because "liquor was not dispensed over the counter," and accusing the same druggist of selling four ounces of laudanum to an intoxicated person.

The writer of the above article demanded the brandy in "soda" water. The clerk declined to give it in that way, on account of a rule of the store forbidding the mixing of any kind of liquor with "soda" water. This rule did not prevent, nor did the clerk refuse, to dispense the brandy in plain water, the effect of which would not be impaired by so doing.

In no case has this druggist refused to dispense brandy over the counter (except in "soda" water) to a sick person when it is needed.

In regard to the other, the person who received the laudanum was *not* intoxicated, and the questions asked him satisfied the clerk that he intended to make a proper use of it.

Yours truly, JUSTICE.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR MR. EDITOR,—Knowing of your great zeal in regard to advanced medical education, I send you a copy of an advertisement I recently found scattered on the seats of an apartment in which a meeting of medical men had been held. It reads thus:

"INTERLINEAL, LITERAL, AND FREE TRANSLATION OF THE DIPLOMA OF THE JEFFERSON MEDICAL COLLEGE."

Price, 50 cents.

May this evidence of *real* progress comfort you in your unrewarded efforts to elevate our professional standard.

"THREE YEARS."

March, 1877.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM FEBRUARY 25, 1877, TO MARCH 10, 1877, INCLUSIVE.

BENTLEY, E., ASSISTANT-SURGEON.—To report to the commanding officer of the 16th Infantry, Custom House New Orleans, La., for temporary duty with that regiment. S. O. 31, Department of the Gulf, February 20, 1877.

BYRNE, C. B., ASSISTANT-SURGEON.—Assigned to duty at Fort Duncan, Texas. S. O. 40, Department of Texas, March 2, 1877.

PAULDING, H. O., ASSISTANT-SURGEON.—Assigned to duty with battalion 2d Cavalry in the field. S. O. 24, c. s., Department of Dakota.

BROWN, P. R., ASSISTANT-SURGEON.—Assigned to duty with battalion 2d Cavalry in the field. S. O. 24, c. s., Department of Dakota.

SHANNON, W. C., ASSISTANT-SURGEON.—Relieved from duty at Fort Duncan, and assigned to temporary duty at Fort Clark, Texas. S. O. 40, c. s., Department of Texas.